

EXODUS HEALTH CENTER
Dr. David Jockers/ Dr. Adriana Bedford Blaise

INDIVIDUALIZED ADOLESCENT HISTORY FORM

IT'S ALL ABOUT YOUR UNIQUENESS

PATIENT DEMOGRAPHICS

HR#: _____

Childs Name _____ Today's Date ____/____/____

Date of Birth ____/____/____ Current Height: _____ Current Weight: _____ Age: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____ Mother's Mobile _____ DOB ____/____/____

Fathers name: _____ Father's Mobile _____ DOB ____/____/____

Pediatrician/Family MD _____ City & State _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

Other (please explain): _____

Purpose of this visit: ____Wellness Check ____Injury or Accident ____Other Health Challenge

If your adolescent is experiencing **Pain/Discomfort/ please identify, where and for how long?**

Date ____/____/____

Did the problem start ____Gradual ____Sudden ____Unknown

PRESENT HEALTH CHALLENGE (S):

For what health challenge(s) is your child here?

What do you feel is the cause of your child's problem?

When did you first notice this sign of body dysfunction?

Ever had this problem before? _____NO _____YES

If yes when? _____

How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same
 Gradually Worsening On & Off

If yes, why do you think so?

What are the most significant measures you have taken to date to improve your child's present health challenge?

Please list all the healthcare practitioner's seen, treatments rendered, and any results experienced.

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

1. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

2. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

HAS YOUR CHILD EVER SUFFERED FROM: CHECK ALL THAT APPLY

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADH |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: |

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to overgrowth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacteria?

Number of doses of antibiotics has your child taken: _____ in the past 6 months _____ in his/her lifetime

Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly

to the treatment of a past problem.

Vaccination History: _____

PRENATAL HISTORY:

Type of birth attendant: OBGYN CNM LAY MIDWIFE

Location of birth: _____ Home _____ Birthing Center _____ Hospital

Complications During Pregnancy: _____ NO _____ YES List: _____

Ultra Sounds During Pregnancy: _____ NO _____ YES Number: _____

Medications During Pregnancy/ Delivery: _____ NO _____ YES LIST: _____

Birth Intervention: _____ Forceps _____ Vacuum _____ Caesarian: Planned or Emergency

Complications during Delivery: _____ NO _____ YES LIST: _____

Genetic Disorders or disabilities: _____ NO _____ YES LIST: _____

Cigarette or Alcohol Use during Pregnancy: _____ NO _____ YES

Breast fed: _____ NO _____ YES How long? _____ Formula Fed: _____ NO _____ YES How long? _____

CHILDHOOD DISEASES:

Chicken Pox NO/YES AGE: _____ **Mumps** NO/YES AGE: _____

Rubella NO/YES AGE: _____ **Whooping Cough** NO/YES AGE: _____

Rubeola NO/YES AGE: _____ **Other:** NO/YES AGE: _____

According to the National Safety Council, Approximately 50% of all children Fall head first from a high place during their first year of life (ie: a Bed , changing table, down stairs, etc) Was this the case with your Child?

_____ No _____ Yes

Has your child ever been hospitalized? ____ Yes ____ No

If yes, why and when? (Please list in chronological order)

DAILY ACTIVITES INVENTORY

How many hours of sleep a night does your child get? _____ Quality: Poor Fair Good

How many hours of screen (computer, phone ipad ,TV) time does your child participate in daily? _____

How many Hours of home Work does your child have per day? _____

How many hour of physical activity does your child get per day? _____

Please list the (3) most common foods eaten by your child each day.

How many times per month does your child eat fast food? _____
What type?

What is the primary beverage consumed by your child?

How much water does your child drink each day?

Does your child drink soda? Yes No If yes, how much on a daily basis?

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? Yes No
If yes, what type of artificial sweeteners does your child use?

Has your child exhibited any tolerance and/or allergy to any specific food? Yes No
If yes, please list all foods. _____

Has your child been tested for allergies? Yes No

If yes, how were the tests performed?

What were the results? _____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms)

Has your child received treatment for any type allergy? __Yes __No
If yes, what type of treatment?

I understand that I am directly and fully responsible to **EXODUS HEALTH CENTER for all fees associated with chiropractic care my child receives.**

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

DATE

Doctor Signature

DATE